Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: 4600 TEXAS GROUP 2777 ALLEN PARKWAY STE 460 HOUSTON TX 77019	MFDR Tracking #:	M4-09-B303-01
Respondent Name and Box #: HARTFORD INS CO OF THE MIDWEST Carrier Rep Box #: 47		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

The Requestor did not submit a position summary along with the DWC060 package.

Principal Documentation:

1. DWC060
2. Affidavit

Total Amount Sought $2,994.76

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondents' Position Summary: Taken from the carrier's letter dated August 21, 2009 states, "…PLN 1 filed claim denied."

Principal Documentation:

1. DWC060 Response
2. TWCC - 21

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Calculations	Amount in Dispute	Amount Due
Unspecified on the Table of Disputed Services	Unspecified on the Table of Disputed Services	N/A	$2,994.76	$0
			Total Due:	$0

PART V: FINDINGS AND DECISION

This Medical Fee Dispute is decided pursuant to Tex. Lab. Code Ann. § 413.031,and Tex. Lab. Code Ann. §§ 409.009, and 409.0091 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted Rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. The provisions of Tex. Lab. Code Ann. §§ 409.009, and 409.0091 apply to dispute resolution.
2. Tex. Lab. Code Ann. § 409.0091 applies only to dates of injury on or after September 1, 2007 **except** as provided by Sec. 409.0091(s).
3. Sec. 409.0091(s) states that if information was provided to a health care insurer before January 1, 2007 under Section 402.084(c-3), the health care insurer may file for reimbursement from the workers' compensation carrier not later than March 1, 2008; and may file a subclaim with the division if the request for reimbursement has been presented and denied not later than March 1, 2008.
4. Tex. Lab. Code Ann. § 409.0091(f) relates to the form and manner in which the health care insurer shall file for reimbursement from the workers' compensation insurance carrier.
5. 28 Tex. Admin. Code §§ 140.6, 140.8 and 28 Tex. Admin. Code §133.307 set out the procedures for health care insurers to pursue medical fee dispute resolution.

Issues

In reference to the health care insurer's / subclaimant's request for medical fee dispute resolution, the division will address the following:

- Did the requestor file for dispute resolution in accordance with Tex. Lab. Code Ann. §409.009?
- Did the requestor file for dispute resolution in accordance with Tex. Lab. Code Ann. §409.0091?
- Did the requestor file for dispute resolution in accordance with 28 Tex. Admin. Code §133.307?

In reference to the health care insurer's / subclaimant's request for reimbursement from the workers' compensation insurance carrier, the division will address the following:

- Was the requestor eligible to file for reimbursement from the workers' compensation insurance carrier under Tex. Lab. Code Ann. § 409.0091?
- Did the requestor file for reimbursement from the workers' compensation insurance carrier in a timely manner as defined by Tex. Lab. Code Ann. § 409.0091(s)?
- Did the requestor file for reimbursement from the workers' compensation insurance carrier in the form and manner prescribed by Tex. Lab. Code Ann. § 409.0091(f)?

Findings

A document titled "Affidavit of Mr. Caldwell Fletcher" found in the dispute point to the requestor's wish to be considered a subclaimant under Tex. Lab. Code Ann. §409.009.

1. **Subclaimant under Tex. Lab. Code Ann. §409.009**

   Tex. Lab. Code Ann. §409.009 allows for any person who has provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee and has sought and been refused reimbursement by the insurance carrier may pursue dispute resolution. 28 Tex. Admin. Code §140.6 sets out the procedures for a subclaimant under §409.009 to file for medical dispute resolution. 28 Tex. Admin. §140.6 states, in pertinent part, that subclaimants must pursue a claim for reimbursement of medical benefits and participate in medical dispute resolution in the same manner as an injured employee or in the same manner as a health care provider, as appropriate, under Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments).

   - **Improper Billing.** The Requestor has provided no information that: (a) the Respondent billed the insurance carrier utilizing the required standard forms used by the Center for Medicare and Medicaid Services in accordance with 28 Tex. Admin. Code §133.10(a)(1); (b) the Respondent billed the carrier no later than the 95th day after the date the services are provided in accordance with 28 Tex. Admin. Code § 133.20(b); (c) the requestor included correct billing codes from the applicable Division fee guidelines in accordance with 28 Tex. Admin. Code §133.20 (c) and §134.203 (b)(1) that requires use of Medicare payment policies including its coding and billing; and/or (d) that the services were directly supervised by a licensed health care provider as required by 28 Tex. Admin. Code § 134.203(e) (2). Therefore, because the Requestor has not met any or the entire rule requirements specified, consideration has not been given to the merits of the request for reimbursement.

- **Improper Medical Fee Dispute Resolution Request.** The Requestor was required to complete, its request for medical fee dispute resolution on Division Form DWC060 and attach the "Table of Disputed Services" in accordance with 28 Tex. Admin. Code § 133.307(c). Rather than completing that Table and for each date of service, listing the applicable CPT Code(s), Medical Fee Guideline MAR amount, and County Where Services were Rendered, the Requestor simply referred to a total amount in dispute as $2,994.76. The attachment to that Table consisted of claim summaries and a "Workers Compensation Itemization" prepared by The 4600 Group that contained summary of services that were provided. This information does not comply with the requirements of a request for medical fee dispute resolution that include providing "…the form DWC060 table listing the specific disputed health care and charges in the form and manner prescribed by the Division and a position statement of how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues and how the submitted documentation supports the requestor's position for each disputed fee issue in accordance with 28 Tex. Admin. Code §133.307(2) and (2)(C), and (F)(iii) and (iv). The Division's medical fee dispute resolution rule authorizes no consideration of requested reimbursement amounts if the requestor has not complied with these specified rules. Therefore, consideration has not been given to the merits of the requested reimbursement amounts. Furthermore, notwithstanding the above-specified deficiencies, no computation of any reimbursement amounts is possible without the applicable bills which would help identify in which locality the services were rendered in order to determine the MAR amount.

2. **Subclaimant under Tex. Lab. Code Ann. §409.0091**

Tex. Lab. Code Ann. §409.0091 outlines the process by which a health care insurer as defined by Tex. Lab. Code Ann. §402.084(c-1) may be reimbursed by a workers' compensation insurance carrier. The services in dispute relate to an injury that occurred on 05/15/02. A data match under Tex. Lab. Code Ann. § 402.084(c-3) is therefore required by Tex. Lab. Code Ann. § 409.0091(s).

- **Data Match Requirement Not Met.** The requestor provided a document titled "Affidavit of Caldwell Fletcher" which indicates that a data match occurred on July 9, 2007. On April 28, 2009, MFDR requested the original data file sent from the division with the data matches so that we [MFDR] may verify the information. As stated in the affidavit, documentation to sufficiently support that a data match occurred on July 9, 2007 was not provided. Therefore, the requestor is not eligible to file for reimbursement under Tex. Lab. Code Ann. § 409.0091. Additionally, a data match had to have occurred before January 1, 2007 in order for the health care insurer (the requestor in this dispute) to file for reimbursement from the workers' compensation insurance carrier. The requestors alleged data match date of on July 9, 2007 does not meet the requirements of Tex. Lab. Code Ann. § 409.0091(s). No documentation was found to support that a data match occurred on January 1, 2007; therefore, the requestor was not eligible to file for reimbursement from the workers' compensation insurance carrier.

- **Untimely Submission for Reimbursement.** The requestor provided insufficient documentation to support that a request for reimbursement was filed before March 1, 2008. Additionally, the requestor was not eligible to file for reimbursement from the workers' compensation carrier because the data match requirements in Sec. 409.0091 (s) were not met as discussed above.

- **Improper Submission for Reimbursement.** Tex. Lab. Code Ann. § 409.0091(f) states in pertinent part "…the health care insurer shall provide, with any reimbursement request, the tax identification number of the health care insurer and the following to the workers' compensation insurance carrier, in a form prescribed by the division: (1) information identifying the workers' compensation case, including: … and (2) information describing the health care paid by the health care insurer, including:…" The division prescribed DWC Form-026 to meet the requirements under Tex. Lab. Code Ann. § 409.0091(f). No documentation was found to sufficiently support that the requestor included DWC Form-026 with the request for reimbursement. The dates of service and the pertinent description of the services (e.g. ICD-9, CPT, HCPCS, NDC or revenue code), among other information required by that form, were not provided and the Requester simply referred to "see attached" and a total amount. Therefore, the requestor was not eligible for reimbursement because the request was not filed in the form and manner prescribed by the Division.

- **Unresolved Compensability, Extent of Injury and/or Liability Issues**. Review of the response to the DWC060 request and a TWCC-21 indicates that there are unresolved issues of compensability, extent of injury and/or liability. Pursuant to dispute resolution in general under Tex. Lab. Code Ann. §409.0091, and in accordance with the dispute resolution processes defined for subclaimants under 28 Tex. Admin. Code § 140.6(d) (1), the requestor must participate in medical fee dispute resolution in the same manner as an injured employee or in the same manner as a health care provider. 28 Tex. Admin. Code §140.8 (h) states that issues of compensability, extent of injury and/or liability and medical necessity must be resolved prior to pursuing a medical fee dispute under 28 Tex. Admin. Code § 133.307. 28 Tex. Admin. Code section 133.307(e) (3) (H) requires that compensability, extent of injury and/or liability issues be resolved through the Tex. Lab. Code Chapter 410 dispute resolution processes prior to medical fee dispute resolution. 28 Tex. Admin. Code §140.8 (h) (1) (A) goes on to state that the appropriate dispute process for unresolved issues of extent requires filing for a benefit review conference pursuant to § 141.1. The division notes that on April 28, 2009 the requestor was given written educational information related to the appropriate dispute process. No documentation was found to support that the issues of compensability, extent of injury and/or liability have been resolved. Therefore, the requestor has failed to support that the services are eligible for medical fee dispute resolution under 28 Tex. Admin. Code §133.307.

Conclusion

For each of the reasons stated, the division finds that the requestor has failed to establish that reimbursement in the amount of $2,994.76 is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the division has determined that the Requestor is entitled to $0.00 reimbursement.

Authorized Signature	Medical Fee Dispute Resolution Auditor	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.